



Figure 1 Recovery of 30 distinguishable strains of *Neisseria gonorrhoeae* from charcoal transport medium stored at ambient temperature or 4°C. *NR, none recovered (≤ 0.82).

To address this we compared the survival of 30 distinguishable clinical strains of NG in charcoal transport swabs held at ambient temperature (AT: 20–22°C) and at 4°C.

Swabs (Transwab; Medical Wire & Equipment Co) were inoculated with a suspension of NG in phosphate buffered saline (PBS). For each strain, four swabs were inoculated, to allow comparison of storage at AT or 4°C, for 24 or 48 hours. At times 24 hours and 48 hours, NG organisms were recovered from swabs by vortexing the tips in 1 ml PBS. Triplicate counts were performed on the 0 hour inocula and the washings on chocolate agar (Oxoid, Basingstoke, UK) using a spiral plater (Don Whitley, Shipley, UK). The median value for each triplicate was taken, and counts compared using the Wilcoxon rank sum test.

At 24 hours there was no significant difference between AT and 4°C counts, with median (interquartile range, IQR) recoverable \log_{10} cfu of 4.57 (3.78–4.84) and 4.72 (4.32–4.87), respectively (fig 1). At 24 hours one strain held at AT was not recovered (see fig 1). At 48 hours, six strains held at AT and three at 4°C were not recovered; median counts (IQR) were 3.09 (1.3–3.55) and 3.855 (3.19–4.53) for AT and 4°C, respectively ($p = 0.004$).

Sng *et al* in a semiquantitative study tested five strains in Amies medium at four temperatures (4, 18, 26, and 32°C) and found better survival at lower temperatures.² Arbique *et al* studied six isolates and found refrigeration improved recovery, though optimum temperature varied with system.³ Perry *et al*⁴ using 11 isolates considered that 4°C prolonged survival. Studies using laboratory control strains of NG have usually shown better recovery at 4°C.^{5–6}

It is impossible to reproduce in vitro the NG inoculum and other conditions in clinical swabs. To demonstrate a difference in survival at two temperatures we used a standardised inoculum higher than that likely to be present in clinical samples. Nevertheless, our results add to a growing body of evidence that, compared to AT, refrigeration does not compromise the recovery of NG. Storage at 4°C offers the potential benefit of reducing overgrowth and elimination of NG by contaminating normal flora.

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Table 1 Chlamydia prevalence by age in men attending GUM clinic and undergoing community based testing

Age groups	Postal testing	GUM 2002	GUM 2003
<15	6.7% (1/15)	16.7% (1/6)	0.0% (0/7)
15–19	13.7% (57/416)	14.2% (50/351)	19.4% (74/382)
20–24	12.6% (42/334)	17.4% (208/1194)	16.7% (217/1299)
25–29	12.0% (14/117)	13.0% (128/981)	11.3% (108/953)
>29	1.4% (1/70)	6.7% (116/1725)	6.3% (101/1598)
Total	12.0% (115/952)	11.8% (504/4258)	11.8% (500/4239)

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Chlamydia in heterosexual men: could peak prevalence be in teenagers?

The CMO's expert advisory group on *Chlamydia trachomatis*¹ and the Health Protection Agency (HPA)² both state that rates of chlamydial infection are highest among 16–19 year old females and 20–24 year old males. Staff based in the genitourinary medicine (GUM) department in Edinburgh have set up a number of community based initiatives, including a postal testing service, to improve access to chlamydia diagnosis for young people aged less than 25. Many of these initiatives have been targeted specifically at young men, with testing having been made available in a variety of novel settings such as young people's sexual health and drop-in clinics, further education (FE) colleges, community pharmacies, sports centres, and a high street shop selling CDs. The work forms part of a demonstration project called Healthy Respect that is funded by the Scottish Executive with the aim of helping young people in Lothian develop a positive attitude to their own sexuality and that of others. The long term goal of the project is to reduce teenage pregnancies and sexually transmitted infections.

Between February 2002 and December 2003, as part of the Healthy Respect project, we carried out 4838 chlamydia tests including 2321 from postal testing kits. The overall

prevalence of chlamydial infection was 9.5% (10.4% in men, 9.0% in women). Somewhat to our surprise, the 15–19 year old age group showed peak prevalence in men as well as in women.

We compared this with the prevalence by age in men attending Edinburgh GUM (see table 1), anticipating this would be highest in the 20–24 year old age group. Although this was the case for 2002, in 2003 the peak prevalence was in 15–19 year olds, with the proportion of all positive tests in men as a result of the under 20s increasing significantly from 10.1% (51/504) in 2002 to 14.8% (74/500) in 2003 (χ^2 5.05; $p = 0.025$).

There is no doubt that in men, the age group 20–24 accounts for the highest number of cases diagnosed, but our data raise the possibility that either there has been under-diagnosis of cases in younger men or that there is a trend towards younger transmission. Although we only report on 2 years' data, it will be essential to monitor ensuing trends by concentrating efforts to include teenage men in chlamydia testing programmes.

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CORRECTIONS

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In two letters published in the June 2004 issue of STI the author list was printed in the incorrect order (F Burns, C H Mercer, D Mercey, S T Sadiq, B Curran, P Kell. Barriers to HIV testing: a survey of GUM clinic attendees. *Sex Transm Infect* 2004;**80**: 247–248. F Burns, C H Mercer, D Mercey, S T Sadiq, B Curran, P Kell. Factors that may increase HIV testing uptake in those who decline to test. *Sex Transm Infect* 2004;**80**:249). S T Sadiq should be the last author for both letters.